DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 03-03

2. STATE: ILLINOIS

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE:
January 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Sections 1905 (a)(26) and 1934 of the Soc. Sec. Act

7. FEDERAL BUDGET IMPACT
a. FFY 03 $0
b. FFY 04 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT.
3.1(a)(1) p. 19b; 3.1(a)(2) p. 20b; Attachment 3.1-A p. 10; Attachment 3.1B p. 9; Supplement 3 to Attachment 3.1A pages 1-8 (new)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
3.1(a)(1) p. 19b; 3.1(a)(2) p. 20b; Attachment 3.1-A p. 10; Attachment 3.1B p. 9

10. SUBJECT OF AMENDMENT:

PACE

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL:
A George Hovanec

13 TYPED NAME: **A. George Hovanec**

14. TITLE: **DIRECTOR**

15. DATE SUBMITTED 1.10.03

16. RETURN TO:

ILLINOIS DEPARTMENT OF PUBLIC AID
201 SOUTH GRAND AVENUE, EAST
SPRINGFIELD, IL. 62763-0001
ATTENTION: Suzanne Baase

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: JAN 10 2003

18. DATE APPROVED: 2/21/03

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:
Alan Fried, acting

21. TYPED NAME:
Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

State of Illinois

Citation 3.1(a) (1) AMOUNT, DURATION, AND SCOPE OF SERVICES: CATEGORICALLY NEEDY (CONTINUED)

		(vi)	Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan.
1902 (e) (7) of the Act		(vii)	Inpatient services that are being furnished to infants and children described in section 1902 (1) (1) (B) through (D), or section 1905 (n) (2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State Plan will continue until the end of the stay for which the inpatient services are furnished.
1902 (e) (9) of the Act	x	(viii)	Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1 (h) of this plan.
1902 (a) (52) and 1925 of the Act		(ix)	Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan.
1905 (a) (23) and 1929		(x)	Home and Community care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A.
1905 (a) (26) and 1934	x	(xi)	Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

State of Illinois

Citation 3.1(a) (2) AMOUNT, DURATION, AND SCOPE OF SERVICES: MEDICALLY NEEDY (CONTINUED)

1902 (e) (9) of the Act	x	(x)	Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1 (h) of this plan.
1905 (a) (23) and 1929		(xi)	Home and Community care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A.
1905 (a) (26) and 1934	x	(xii)	Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the services provided to each covered group of the medically needy, specifies all limitations on the amount, duration and scope of those items, and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

State of Illinois

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____ provided ___x___ not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not member of the individual's family, and (c) furnished in a home.

___ Provided:
- ___ State Approved (Not Physician) Service Plan Allowed
- ___ Services Outside the Home Also Allowed
- ___ Limitations Described on Attachment

_x__ Not Provided.

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

_X__ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

____ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

State of Illinois

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All – specified in Item C of Attachment 2.2-A

24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____ provided ___x___ not provided

25. Personal care services furnished to an individual who is not an inpatient or resident of hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not member of the individual's family, and (c) furnished in a home.

___ Provided:
- ___ State Approved (Not Physician) Service Plan Allowed
- ___ Services Outside the Home Also Allowed
- ___ Limitations Described on Attachment

x Not Provided.

26. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

X Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

____ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

State of Illinois
PACE State Plan Amendment Pre-Print

Name and address of State Administering Agency, if different from the State Medicaid Agency.

I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A._____The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

B. _____The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals.

C._____The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

Regular Post Eligibility

1.____ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a). Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.

State of Illinois
PACE State Plan Amendment Pre-Print

1. Allowances for the needs of the:
   (A.) Individual (check one)
      1.____The following standard included under the State plan (check one):
         (a) _____SSI
         (b) _____Medically Needy
         (c) _____The special income level for the institutionalized
         (d) _____Percent of the Federal Poverty Level: _____%
         (e) _____Other (specify):_____
      2._____The following dollar amount: $_____
         Note: If this amount changes, this item will be revised.
      3._____The following formula is used to determine the needs allowance:

         _____
         _____

   Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

   (B.) Spouse only (check one):
      1.____ SSI Standard
      2.____ Optional State Supplement Standard
      3.____ Medically Needy Income Standard
      4.____ The following dollar amount: $_____
         Note: If this amount changes, this item will be revised.
      5 .____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
      6.____ The amount is determined using the following formula:

         _____
         _____

      7.____ Not applicable (N/A)

State of Illinois
PACE State Plan Amendment Pre-Print

(C.) Family (check one):

1.____ AFDC need standard
2.____ Medically needy income standard
The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.
3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.____ The following percentage of the following standard that is not greater than the standards above:_____%
of_____ standard.
5.____ The amount is determined using the following formula:
_____
_____
6.____ Other
7.____ Not applicable (N/A)

(2). Medical and remedial care expenses in 42 CFR 435.726.

Regular Post Eligibility

2. _____ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) 42 CFR 435.735--States using more restrictive requirements than SSI.

1. Allowances for the needs of the:
   (A.) Individual (check one)
      1.___The following standard included under the State plan (check one):
         (a) _____SSI
         (b) _____Medically Needy
         (c) _____The special income level for the institutionalized
         (d) _____Percent of the Federal Poverty Level: _____%
         (e) _____Other (specify):_____
      2.___The following dollar amount: $_____
         Note: If this amount changes, this item will be revised.
      3.___The following formula is used to determine the needs allowance:

      _____
      _____
      Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

   (B.) Spouse only (check one):
      1. _____ The following standard under 42 CFR 435.121:
         _____
      2. _____ The Medically needy income standard
         _____
      3. _____ The following dollar amount: $_____
         Note: If this amount changes, this item will be revised.
      4. _____ The following percentage of the following standard that is not greater than the standards above: ____% of _____ standard.
      5. _____ The amount is determined using the following formula:
         _____
         _____
         _____
      6._____Not applicable (N/A)

(C.) Family (check one):

1.____AFDC need standard
2.____Medically needy income standard
The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.
3.____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.____The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.
5.____ The amount is determined using the following formula:
_____
6.____ Other
7.____ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

3.____ State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:

1. Individual (check one)

(A).____The following standard included under the State plan (check one):

1. _____SSI
2. _____Medically Needy
3. _____The special income level for the institutionalized
4. _____Percent of the Federal Poverty Level: _____%
5. _____Other (specify):_____

(B).____The following dollar amount: $_____

Note: If this amount changes, this item will be revised.

(C)_____The following formula is used to determine the needs allowance:

_____

_____

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

_____

_____

_____

_____

_____

_____

II. Rates and Payments

A. The State assures HCFA that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach (see below) a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

1. X Rates are set at a percent of fee-for-service costs
2. ___ Experience-based (contractors/State's cost experience or encounter date)(please describe)
3. ___ Adjusted Community Rate (please describe)
4. ___ Other (please describe)

Rate Setting Methodology

Reimbursement shall be in the form of a monthly capitation rate. The rate shall be negotiated with the provider but shall not exceed 95 percent of the amount that would have been expended by the Department to provide the same services to an actuarially similar population, as determined by the Department from its paid claim records.

The actuarially similar population shall be comprised of Medical Assistance beneficiaries residing within the geographic area served by the PACE provider who, during the most recent State fiscal year ending no more recently than six months prior to this determination, was determined to have the level of need necessary to be either a resident of a nursing facility or a participant in a home- and community-based (waiver) program. This population shall be adjusted to provide that the distribution of individuals, with respect to age and level of need, is the same as that enrolled with the PACE provider. Level of need shall be that measured and reported through the use of the State's long term care pre-admission screening tool. The resulting amount shall be adjusted to reflect the change in estimated expenditures from the fiscal year upon which the rate was calculated and the current fiscal year. The rates shall be re-evaluated annually.

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

C. The State will submit all capitated rates to the HCFA Regional Office for prior approval.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

IV. Limitations

A. Provider Enrollment

The State reserves the right to limit provider participation to those providers acceptable to both the State Agency and the U.S. Department of Health and Human Services.

B. Eligible Population

The State reserves the right to place the following participant eligibility limitations on the program:

1. Limit the total number of enrollees to 600;
2. Limit those eligible to those residing in the geographic area of the provider;
3. Limit those eligible to persons at or above 55 years of age;
4. Limit those eligible to persons with a level of need appropriate for care in a nursing facility.